House
Legislative
Analysis
Section

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HEALTH INSURANCE: SMALL GROUP MARKET

House Bill 4553 (Substitute H-3)
Sponsor: Rep. Stephen Ehardt

House Bill 4279 (Substitute H-3)
Sponsor: Rep. William J. O'Neil

House Bill 4280 (Substitute H-1)
Sponsor: Rep. David Robertson

House Bill 4281 (Substitute H-2)
Sponsor: Rep. David Farhat

House Bill 4282 (Substitute H-1)
Sponsor: Rep. Edward Gaffney

First Analysis (5-29-03)
Committee: Health Policy

THE APPARENT PROBLEM:

Blue Cross Blue Shield of Michigan (BCBSM) is defined by statute as a nonprofit, charitable, and benevolent organization. In exchange for an exemption from state and local taxes, BCBSM acts as the state's "insurer of last resort," meaning that it must offer coverage to all state residents. Not coincidentally, BCBSM is also the largest insurer in the state. In 2001 alone, BCBSM paid $5.8 billion in benefits for services provided to over 4.8 million members. About 95 percent of the state's allopathic and osteopathic physicians, 99 percent of the state's pharmacies, and all of the state's hospitals "participate" with BCBSM, meaning that they have contracts binding them to accept BCBSM payment as full payment (except for copays and deductibles) for covered services.

Since World War II, Americans have come to rely on their employers for access to health insurance. While BCBSM acts as an insurer of last resort in Michigan, and thus any individual who wants coverage can get it, employers are in a better position to negotiate rates with carriers because they represent a number of potential members among whom risk can be shared. One factor affecting employers' ability to purchase health insurance is the number of workers in their group: because health insurance involves spreading risk and costs among members of a group, the larger and more diverse the group, the better the group is able to absorb the costs incurred by any given member. Generally speaking, larger employer groups are less likely to be financially affected by the occurrence of unexpected catastrophic illnesses than smaller employer groups, and thus large employers enjoy a distinct advantage when shopping for health insurance. They are usually in a better position to negotiate rates with insurers and HMOs, and they are in a better position to opt out of the insurance market and self-insure.

Federal law has relieved BCBSM of its role as insurer of last resort in the small group health insurance market. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") helps guarantee small employers—defined as having 2-50 employees--the right to purchase group health insurance coverage for their employees by (generally speaking) requiring insurers that sell such coverage to *any* small employer to offer coverage to *all* small employers. Yet HIPAA's guarantee of access to health insurance does not include a guarantee that the health insurance itself will be affordable. Though it restricts the use of pre-existing conditions in determining premium rates and prohibits the issuer of a health benefit plan from charging individual employees of a given employer different premiums based on their health status, HIPAA does not place any restrictions on what a carrier may charge for

coverage offered to a small employer group as a whole. Finally, it must be noted that the extent to which carriers in the state are complying with HIPAA remains unclear: because Michigan had certain HIPAA-like requirements on the books prior to HIPAA's enactment, federal regulators have given the state some flexibility with regard to the timeline for enacting state HIPAA legislation.

According to information provided by the Office of Financial and Insurance Services, 57 percent of the 1.9 million Michiganians covered in the small employer group health insurance market during 2000 were covered by BCBSM and another 14 percent were covered by Blue Care Network of Michigan, a health maintenance organization (HMO) owned by BCBSM. Gerber Life Insurance Company had 11 percent of the small group market, and other commercial insurers and HMOs accounted for the remaining 18 percent, with none of these entities having a market share greater than 5 percent. While having a large market share is generally desirable, BCBSM has had difficulties in the small employer health insurance market in recent years: a 2001 audit of BCBSM revealed that the company had lost over $400 million in the small group market between 1995 and 2000.

How did this happen? Explanations differ widely. Critics argue that antiquated information systems, inadequate returns on investments, mismanagement, and an oversized and inefficient board structure contributed to BCBSM's problems. Some have accused BCBSM of selling group plans at artificially low prices and then writing off its debt as an asset (albeit legally), allowing it to maintain the appearance of fiscal soundness until a commissioner's audit revealed otherwise. As long as rates were low, small businesses were happy, but as soon as their BCBSM rates started reflecting market realities, they started complaining. Critics believe that BCBSM is a relic of times past, a state-supported monopoly whose tax exemptions and enormous market share give it little incentive to reform. They suggest that the real test for BCBSM would be to see how long the company would stand if the state were to take away the tax exemptions propping it up.

Defenders of BCBSM argue that restrictions on its ability to set rates, in conjunction with the lack of any comparable restrictions on commercial carriers, make it easy for the commercial carriers to engage in "adverse risk selection" or "cherry picking", where they charge higher rates than BCBSM can charge for the oldest, least healthy groups and lower rates than BCBSM can charge for the younger and healthier groups. Commercial insurers are able to do this by using factors such as age and health status when determining their rates. BCBSM uses "adjusted community rating," meaning that its rates vary based on geography, family composition, industry, and benefit plan. While commercial carriers may also use these characteristics, the use of age and health status has not been approved for BCBSM, leaving them with few tools to attract the young and healthy groups that they need to offset the costs of their older and sicker groups.

A different type of "cherry picking" occurs when a commercial insurer splits an employer's group, offering two options to an employer: a lower premium per employee option for a subset consisting of the employer's most (actuarially) desirable employees and a higher premium per employee option for the entire group. This gives the employer the option and the incentive to steer certain employees to the commercial plan and other (usually older and sicker) employees to BCBSM. Until 1998, BCBSM was allowed to apply participation rules requiring that an employer insure a certain number or percentage of its employees with BCBSM as a condition of offering coverage. This gave BCBSM some leverage when a small business tried to send its older, sicker employees to BCBSM and its younger, healthier employees to a commercial carrier that could cover those employees inexpensively. But regulators no longer allow the corporation to do this.

According to some people, these disparities between BCBSM and the commercial insurers creates a "death spiral": When commercial insurers offer relatively young and healthy groups significantly lower rates and (relatively) old and unhealthy groups significantly higher rates than BCBSM can offer, the younger, healthier groups choose commercial insurance, and the older, unhealthier groups stay with BCBSM. Because the older, unhealthier groups tend to have greater health care needs, and because BCBSM cannot use age and health status in setting its rates, over time BCBSM must raise its premium rates for all small employer groups. This gives those relatively young and healthy groups still insured by BCBSM added incentive to seek a better deal in the commercial market and increases the likelihood that some small employers will stop offering insurance to their employees. When small employers stop offering insurance to their employees, health insurance becomes a problem not just for small employers but also for the state.

The Small Business Association of Michigan has been one of the most vocal proponents of the "death

spiral" account of the Blues' small group market problems. Many small businesses have insurance through BCBSM. According to the SBAM Health Care Task Force's January 2003 "Final Report and Recommendations", premiums for small businesses have risen between 20 and 25 percent per year on average for the past five years. The report cites an EPIC/MRA poll suggesting that 40 percent of small business owners have had to increase the price of goods and services to compensate for the increased cost of health care and that nearly a quarter of all small businesses in the state fear that the cost of health insurance will drive them out of business. Other small businesses have stopped offering coverage, hindering their ability to attract and retain employees for whom health insurance is often a critical benefit and contributing to the ranks of the uninsured.

What is the solution? While many small businesses are currently insured by BCBSM, SBAM argues that small businesses would prefer a competitive health insurance market in which they have a number of different health care options. One way to increase competition would be to require all carriers to play by the same rules: require commercial carriers, HMOs, and BCBSM to use adjusted community rating; or allow them all to use health status, age, and the other characteristics that commercial carriers can use currently; or else find some middle ground. Critics of this possibility suggest that it fails to acknowledge the very real differences between the historic missions of each type of carrier and, perhaps more to the point, fails to acknowledge the very real tax benefits that BCBSM receives as the state's only nonprofit health care corporation. They argue that different rating characteristics and rules should be instituted for the different types of carriers. SBAM argues that while this approach would be inappropriate in a "pure public policy context", it "recognizes that each of the carrier groups has advantages and disadvantages in the marketplace currently and that some 'texturing' of the rules may serve the goal of creating a competitive market."

Legislation has been introduced to establish rate bands that will "compress" commercial carriers premium rates and "decompress" BCBSM's premium rates for health benefit plans, to ease certain statutory restrictions on BCBSM, and to bring Michigan's small group health insurance market into compliance with HIPAA requirements.

THE CONTENT OF THE BILLS:

House Bill 4553 would add a new chapter to the Insurance Code of 1956 to regulate health coverage made available to small employers by commercial insurers, Blue Cross Blue Shield of Michigan, and health maintenance organizations (HMO's). The bill is tie-barred to House Bill 4279, which is the main bill in a related package of bills that would amend the Nonprofit Health Care Corporation Act to provide a series of changes in the regulation of Blue Cross Blue Shield of Michigan. The provisions of House Bill 4553 would take effect six months after the bill was enacted.

House Bills 4279-4282 would amend the Nonprofit Health Care Corporation Act, also known as the Blue Cross Blue Shield Act, to ease certain statutory restrictions on Blue Cross Blue Shield of Michigan. House Bill 4279, the primary bill in the package, is tie-barred to House Bill 4553.

A summary of the two main bills, House Bill 4553 and House Bill 4279, follows. The bills are described in greater detail later.

House Bill 4553 would amend the Insurance Code of 1956 (MCL 500.3406q and 500.3701 et al.) to add a new chapter (Chapter 37 – Small Employer Group Health Coverage) to do all of the following:

- allow small employer carriers to establish up to ten geographic areas in the state for use in establishing rates;

- specify which characteristics different types of carriers could use in determining rates;

- establish rate bands limiting the amount by which the premiums charged for a health benefit plan in a geographic area could deviate from the "index rate" for that plan, with the rate bands to be phased in for policies issued before the bill's effective date and later renewed, up until March 1, 2008, when the rate bands would apply equally to all plans;

- allow a carrier to charge a sole proprietor an additional premium of up to 25 percent;

- allow a carrier to charge a sole proprietor or small employer who had previously been self-insured an additional premium of up to 33 percent for two years;

- limit the percentage increase that could be charged to a small employer in a geographic area for a new rating period for plans issued on or after the bill's

effective date and, as of March 1, 2008, for renewals of plans originally issued before that date;

• allow carriers to establish premiums based on plan options, number of family members covered, and Medicare eligibility;

• require carriers to apply rating factors consistently to all small employers and sole proprietors in a geographic area;

• require small employer carriers to bill with a composite rate;

• require BCBSM to cover sole proprietors and require any other carrier offering coverage to sole proprietors to offer all sole proprietors in a geographic area the same plans;

• allow carriers to apply open enrollment periods for sole proprietors, require a carrier applying such a period to offer it annually, and require that the period be at least one month long;

• allow carriers to exclude or limit coverage to sole proprietors for pre-existing conditions, subject to certain constraints;

• require all small employer carriers to make available to all small employers all health benefit plans they market to small employers in the state;

• allow carriers to impose an "affiliation period" for new and late enrollees as long as the period is applied uniformly and without regard to health-status;

• prohibit carriers from offering or selling plans that contain "waiting periods" applicable to new or late enrollees;

• require carriers to accept late enrollees according to the provisions of Chapter 37;

• provide for special enrollment of employees and their dependents under certain conditions;

• require carriers to apply requirements uniformly when determining whether to provide coverage to a small employer;

• permit carriers to apply participation rules, which require a small employer to enroll a certain number or percentage of employees with the small employer carrier as a condition of coverage;

• require carriers to guarantee renewability for all small employer groups, with certain exceptions;

• establish a notification framework and restrict future activity of a carrier who ceases to renew all plans in a geographic area;

• require marketing disclosure notifications and maintenance of information on rating and renewal practices;

• require the commissioner to annually determine whether a reasonable degree of competition exists in the small employer health insurance market and to issue a report delineating his or her findings if there is not sufficient competition (and again if those findings are disputed); and

• authorize the commissioner to suspend rate bands based on the financial impact to the carrier or the overall impact the bands are having on the market.

House Bill 4279 would amend the Nonprofit Health Care Corporation Reform Act (MCL 550.1107 et al.) to do the following:

• provide that BCBSM would be subject to a new Chapter 37 of the Insurance Code (as proposed by House Bill 4553) dealing with health coverage for small employer groups, and specify that when there was a conflict between the BCBSM act and Chapter 37, Chapter 37 would supersede the BCBSM act;

• exempt BCBSM from state and local utility usage taxes and fees;

• require BCBSM to maintain unimpaired surplus in an amount determined adequate by the Commissioner of the Office of Financial and Insurance Services (OFIS), but not greater than 200 percent of the authorized control level under risk based capital requirements multiplied by five;

• allow BCBSM to remedy a deficiency in surplus with planwide viability contributions by subscribers at rates prescribed by the bill;

• require BCBSM to report financial information using statutory accounting principles;

• provide that BCBSM could include age as a factor when determining nongroup and group conversion rates for a certificate that included prescription drug coverage, under certain conditions (House Bill 4281, described later, addresses a proposed prescription drug pilot program);

• permit BCBSM to own or control an insurance company that was authorized only to sell long-term

care insurance (House Bill 4280, described later, also addresses this);

• permit BCBSM to condition the granting of long-term care insurance coverage on an applicant's health history;

• permit BCBSM to enter into contracts with health care providers practicing legally in another jurisdiction (House Bill 4282, described later, also addresses this);

• require BCBSM to wait 60 days before a new certificate, a change to an existing certificate, or a rate charge change could take effect, unless approved by the commissioner before the 60-day period expired;

• allow BCBSM to request that the commissioner hold a hearing on a proposed certificate or rate, and allow the attorney general to request a hearing on a rate filing;

• apply current rate filing and approval requirements to nongroup Medicare supplemental coverage; and

• expand the authority of the attorney general to include enforcement of Chapter 37 of the Insurance Code (which would be created by House Bill 4553), and allow local units of government, state agencies, and other persons to bring actions to ensure enforcement of Chapter 37.

A more detailed description of the bills in this package follows.

House Bill 4553.

Applicability. The bill would add a new chapter to the Insurance Code (Chapter 37: Small Employer Group Health Coverage) applying to "health benefit plans" that provided coverage to a "small employer" and that met one of the following two conditions:

• any portion of the premium or benefits was paid by or on behalf of the small employer or through salary deductions by the small employer;

• an eligible employee or dependent was reimbursed for any portion of the premium, through wage adjustments or otherwise, by or on behalf of the small employer.

Unless the policy met the above criteria, Chapter 37 would not apply to an individual health insurance policy that was subject to policy form and premium approval by the commissioner.

Chapter 37 would apply to each health benefit plan for a small employer or sole proprietor that was delivered, issued for delivery, renewed, or continued in Michigan on or after the (proposed) act's effective date. The continuation date of a health benefit plan would be the first rating period--presumably, the first date of the first rating period--that began on or after that date. (BCBSM would have to make a health benefit plan available to a sole proprietor upon request, and other carriers could do so.)

Definitions. "Health benefit plan" or "plan" would mean an expense-incurred hospital, medical, or surgical policy or certificate, BCBSM certificate, or HMO contract, and would not include any of the following: accident-only, credit, dental, or disability income insurance; long-term care insurance; coverage issued as a supplement to liability insurance; coverage only for a specified disease or illness; worker's compensation or similar insurance; or automobile medical-payment insurance.

"Small employer" would be defined as a person, firm, corporation, partnership, limited liability company, or association actively engaged in business who, on at least 50 percent of its working days during the preceding or current calendar year, employed at least two but not more than 50 "eligible employees". (Companies that were affiliated or eligible to file a combined state tax return would be considered one employer.)

"Eligible employee" would mean an employee who worked on a full-time basis with a normal workweek of 30 or more hours. Additionally, eligible employee could include an employee who worked on a full-time basis with a normal workweek of 20 to 30 hours, if an employer so chose and if the employer applied this eligibility criterion uniformly among all of the employer's employees, without regard to health status-related factors.

A "carrier" would be defined as a person that provided health benefits, coverage, or insurance in the state, including BCBSM, for-profit insurers, HMOs, and multiple employer welfare arrangements, as well as any other person providing a plan of health benefits, coverage, or insurance subject to insurance regulation in Michigan.

A "small employer carrier" would mean a carrier that offered health benefit plans covering employees of a small employer or a carrier that provided health benefit plans to sole proprietors. (As mentioned above, BCBSM would be required to provide a plan to a sole proprietor who requested coverage, and

other carriers could provide a plan to a sole proprietor.)

Geographic areas, rating characteristics, and rate bands. A carrier could establish up to ten "geographic areas" in the state for the purpose of adjusting rates for health benefit plans subject to Chapter 37. A "geographic area" would have to include at least one entire county. If a geographic area included one entire county and additional counties or portions of counties, the counties or portions of counties would have to be contiguous with at least one other county or portion of another county in that geographic area. BCBSM would be required to establish geographic areas covering all counties in Michigan

The bill would allow different types of carriers to use different types of characteristics in determining premiums. In addition, the bill would establish rate bands for each type of carrier. In general, a rate band limits the spread between a carrier's highest and lowest premium rates due to characteristics within the band. Specifically, the bill would limit the amount that a carrier's rates could deviate from its "index rate" and would specify which characteristics fall within the band for each type of carrier.

"Index rate" would be defined as the average (during a rating period) of the base premium and the highest premium charged or that could be charged for each health benefit plan offered by each small employer carrier in a geographic area. "Base premium" would be defined as the lowest premium charged or that could be charged under a rating system by a small group carrier to small employers for a health benefit plan in a geographic area.

Different rate bands would be phased in between the date the (proposed) act took effect and February 29, 2008, after which date small employer carriers would be subject to final rate bands. The allowable characteristics, rate bands, and various phases of implementation are described below.

Different types of carriers could use the following characteristics for determining the premiums in a geographic area for sole employers and sole proprietors as follows:

- BCBSM could use only industry and age, both of which would fall within BCBSM's rate band.

- HMOs could use only industry, age, gender, group size, and duration of coverage, all of which would fall within an HMO's rate band.

- Small employer carriers other than BCBSM or an HMO—e.g., commercial insurers—could use three sets of characteristics: (1) industry, gender, and group size; (2) age; and (3) claims experience, health status, and duration of coverage. The third set of characteristics would be subject to a rate band. The first set of characteristics would fall outside of the rate band. The use of age would fall outside of the rate band initially but eventually would be subject to a maximum premium differential.

Rate bands. The following rate bands would apply to carriers for health benefit plans issued on or after the (proposed) act's effective date. These bands would also eventually apply to a health benefit plan issued before the (proposed) act's effective date, but not until the beginning of the next renewal period for the plan following February 29, 2008:

- for BCBSM, only industry and age could be used for determining the premiums charged during a rating period to small employers and sole proprietors in the same geographic area with the same or similar coverage, and the premiums could not vary from the index rate by more than 35 percent;

- for HMOs, only industry, age, gender, and group size could be used for determining the premiums charged during a rating period to small employers and sole proprietors in the same geographic area with the same or similar coverage, and the premiums could not vary from the index rate by more than 35 percent; and

- for other small employer carriers, industry, age, gender, and group size could be used for determining the premiums in a geographic area for a small employer or sole proprietor located in that area without rating band limitations. However, effective March 1, 2008, the maximum premium differential for age for a health benefit plan in a geographic area would be five to one. Further, claims experience, health status, and duration of coverage could also be used for determining the premiums in a geographic area, but the premiums charged during a rating period to small employers and sole proprietors located in that geographic area with the same or similar coverage for claims experience, health status, and duration of coverage characteristics could not vary from the index rate by more than 35 percent of the index rate.

BCBSM Renewal period ending before March 1, 2005. For a health benefit plan renewal period that ended before March 1, 2005, BCBSM could only use industry and age if the result was to lower the

premium in a geographic area for a small employer or sole proprietor located in that geographic area.

Renewals of previously issued plans occurring March 1, 2005 through February 28, 2006. For a health benefit plan issued before the (proposed) act's effective date, the different types of small employer carriers would be subject to the following rate bands for renewals occurring on or after March 1, 2005 and through February 28, 2006:

- for BCBSM, premiums charged during a rating period to small employers and sole proprietors in a geographic area with the same or similar coverage could not be higher than 10 percent above the index rate nor lower than 20 percent below the index rate;

- for HMOs, premiums charged during a rating period to small employers and sole proprietors in a geographic area with the same or similar coverage could not vary from the index rate by more than 70 percent of the index rate; and

- for small employer carriers other than BCBSM and HMOs, premiums charged during a rating period to small employers and small proprietors with the same or similar coverage, for claims experience, health status, and duration of coverage characteristics, could not vary from the index rate by more than 70 percent of the index rate. (Industry, age, gender, and group size could be used for determining the premiums and would not be subject to the rate band.)

Renewals of previously issued plans occurring March 1, 2006 through February 28, 2007. For a health benefit plan issued before the (proposed) act's effective date, the different types of small employer carriers would be subject to the following rate bands for renewals occurring on or after March 1, 2006 and through February 28, 2007:

- for BCBSM, premiums charged during a rating period to small employers and sole proprietors in a geographic area with the same or similar coverage could not be higher than 20 percent above the index rate nor lower than 30 percent below the index rate;

- for HMOs, premiums charged during a rating period to small employers and sole proprietors in a geographic area with the same or similar coverage could not vary from the index rate by more than 60 percent of the index rate; and

- for small employer carriers other than BCBSM and HMOs, premiums charged during a rating period to small employers and small proprietors with the same or similar coverage, for claims experience, health status, and duration of coverage characteristics, could not vary from the index rate by more than 60 percent of the index rate. (Again, industry, age, gender, and group size could be used for determining the premiums and would not be subject to the rate band.)

Renewals of previously issued plans occurring March 1, 2007 through February 28, 2008. For a health benefit plan issued before the (proposed) act's effective date, the different types of small employer carriers would be subject to the following rate bands for renewals occurring on or after March 1, 2007 and through February 28, 2008:

- for BCBSM, premiums charged during a rating period to small employers and sole proprietors in a geographic area with the same or similar coverage could not be higher than 30 percent above the index rate nor lower than 35 percent below the index rate;

- for HMOs, premiums charged during a rating period to small employers and sole proprietors in a geographic area with the same or similar coverage could not vary from the index rate by more than 50 percent of the index rate; and

- for small employer carriers other than BCBSM and HMOs, premiums charged during a rating period to small employers and small proprietors with the same or similar coverage, for claims experience, health status, and duration of coverage characteristics, could not vary from the index rate by more than 50 percent of the index rate. (Again, industry, age, gender, and group size could be used for determining the premiums and would not be subject to the rate band.)

Exceptions to rate bands. For a sole proprietor, a small employer carrier could charge an additional amount of up to 25 percent above the otherwise allowed premium.

Beginning one year after the (proposed) act's effective date, if a small employer or sole proprietor had been self-insured for health benefits immediately before applying for a health benefit plan under Chapter 37, a carrier could charge an additional premium of up to 33 percent above the otherwise allowed premium for up to two years.

Increase in premium from one rating period to the next. The bill would limit the amount that a premium could increase from one rating period to the next both for health benefit plans issued on or after the (proposed) act's effective date, and after February 29, 2008, for renewals of health benefit plans issued before that date. The percentage increase in the

premium charged to a small employer for a new rating period could not exceed the sum of the following: any adjustment due to change in coverage; the percentage change in the base premium for the health benefit plan; and any adjustment due to change in the characteristics of the group. Adjustments due to a change in the characteristics of the small employer or sole proprietor group would be subject to the following constraints:

- for BCBSM, up to 35 percent annually (and adjusted pro rata for rating periods of less than one year), due to industry and age of the group's members (i.e., the small employer's employees or employees' dependents or of the sole proprietor or the sole proprietor's dependents);

- for an HMO, up to 35 percent annually, due to industry, age, gender, group size and duration of coverage of the group's members;

- for any other small employer carrier, up to 15 percent annually, due to claims experience, health status, and duration of coverage of the group's members.

Rates - other. A small employer carrier would have to apply all rating factors consistently with respect to all small employers and sole proprietors in a geographic area. A small employer carrier could bill a small employer group only with a composite rate and could not bill so that one or more employees in a small employer group were charged a higher premium than another employee in that small employer group. However, health benefit plan options, number of family members, and Medicare eligibility could be used in establishing a small employer or sole proprietor's premium (notwithstanding the general limitations on the amount a carrier could charge different employers for the same coverage.)

Sole proprietors. A small employer carrier could offer an open enrollment period for sole proprietors, and if the carrier did so, the open enrollment period would have to be offered at least annually and would have to be at least one month long. Small employer carriers would not have to offer or provide to sole proprietors all plans available to non-sole proprietor small employers, but would have to offer to all sole proprietors in a geographic area all plans that are available to any sole proprietor in that area.

Small employer carriers could exclude or limit coverage for a sole proprietor for a condition only if the exclusion or limitation related to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within six months before enrollment, and the exclusion or limitation did not extend for more than six months after plan took effect.

A small employer carrier could not impose a preexisting condition exclusion for a sole proprietor that related to pregnancy as a preexisting condition or with regard to a child who was covered under any "creditable coverage" (see below) within 30 days of birth, adoption, or placement for adoption, as long as the child did not experience a significant break in coverage and the child was adopted or placed for adoption before attaining 18 years of age. The period of creditable coverage could not be counted for enrollment of an individual under a health benefit plan if, after this period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage. For purposes of calculating periods of creditable coverage, a "waiting period" would not be considered a gap in coverage. (See below for the definition of "waiting period".)

"Creditable coverage" would be defined as health benefits, coverage, or insurance provided to an individual under any of the following: a "group health plan" (that is, an employee welfare benefit plan as defined in the federal Employee Retirement Income Security Act); a health benefit plan; Medicare (Parts A or B); Medicaid (with the exception of benefits provided under a section of the Social Security Act dealing with home and community care for functionally disabled elderly individuals); medical and dental plans for personnel of the U.S. Armed Forces, the commissioned corps of the National Oceanic and Atmospheric Administration, and the Public Health Service; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under the (federal government) Employees Health Benefits Program; a plan established or maintained by a state, county, or other political subdivision of a state providing health insurance coverage to individuals enrolled in the plan; and a health benefit plan for U.S. Peace Corps volunteers.

Offer to one, offer to all (or "guaranteed issue"). As a condition of doing business in Michigan with small employers, every small employer carrier would be required to make available to small employers all plans that it "marketed" to small employers in the state. A small employer carrier would be considered to be *marketing* a plan if it offered the plan to a small employer not currently receiving a plan from that

small employer carrier. A small employer carrier would be required to issue any health benefit plan to any small employer that applied for the plan and agreed both to make the required premium payments and to satisfy any other provisions of the plan that were reasonable and consistent with Chapter 37.

Affiliation period/waiting period. In general, a small employer carrier could not offer or sell to small employers a health benefit plan that contained a "waiting period" applicable to new or late enrollees. "Waiting period" would mean, with respect to a health benefit plan and a potential enrollee in the plan, a period that must pass with respect to the individual before the individual was eligible to be covered for benefits under the terms of the plan.

However, a small employer carrier could offer or sell to small employers other than sole proprietors a health benefit plan that provided for an "affiliation period" that had to expire before coverage became effective for a new or late enrollee. "Affiliation period" would be defined as a period of time required by a small employer carrier that had to expire before health coverage became effective. A small employer carrier could only offer or sell a plan providing for an affiliation period if the following conditions were met:

- the affiliation period was applied uniformly to all new and late enrollees (and their dependents) of the small employer, without regard to any health status-related factor;

- the affiliation period did not exceed 60 days for new enrollees and did not exceed 90 days for late enrollees;

- the small employer carrier did not charge any premiums for the enrollee during the affiliation period; and

- the coverage issued was not effective for the enrollee during the affiliation period.

Late enrollees. A health benefit plan offered to a small employer by a small employer carrier would have to provide for the acceptance of late enrollees. A small employer carrier would have to permit an employee or a dependent of the employee, who was eligible but not enrolled, to enroll for coverage under the terms of the small employer health benefit plan during a special enrollment period if all of the following applied:

- the employee or dependent was covered under a group health plan or had coverage under a plan at the time coverage was previously offered to the employee or dependent;

- the employee stated in writing at the time coverage was previously offered that coverage under a group health plan or other plan was the reason for declining enrollment (but only if the small employer or carrier required such a statement at the time coverage was previously offered and provided notice to the employee of the requirement and the consequences of the requirement at that time); and

- the employee or dependent's (other) coverage was either (a) under a COBRA (see below) continuation provision and that coverage had been exhausted or (b) was not under a COBRA continuation provision and that other coverage had been terminated as a result of loss of eligibility for coverage, for reasons that could include legal separation, divorce, death, termination of employment, reduction in the number of hours of employment or termination of employer contributions toward that other coverage. (Whether or not the employee or dependent's other coverage was under a COBRA continuation provision, the employee could not request enrollment later than 30 days after the date of exhaustion or termination of coverage or termination of employer contributions.)

"Dependent special enrollment period". A small employer carrier that made dependent coverage available under a plan would have to provide for a dependent special enrollment period during which a person could be enrolled under the plan as a dependent of the individual or, if not otherwise enrolled, the individual could be enrolled under the plan. For a child's birth or adoption, the spouse of the individual could be enrolled as a dependent of the individual if the spouse was otherwise eligible for coverage. To be eligible to enroll during this dependent special enrollment period both of the following criteria would have to be met:

- the individual was a participant under the plan or had met any affiliation period applicable to becoming a participant under the plan and was eligible to be enrolled under the plan (except for a failure to enroll during a previous enrollment period); and

- the person became a dependent of the individual through marriage, birth, or adoption or placement for adoption.

The dependent special enrollment period could not be less than 30 days long, beginning on the later of the

date dependent coverage was made available or the date of the marriage, birth, or adoption or placement for adoption. If an individual sought to enroll a dependent during the first 30 days of the period, the dependent's coverage would be effective as follows:

- for marriage, not later than the first day of the first month beginning after the date the completed request for enrollment was received;

- for a dependent's birth, as of the date of birth; and

- for a dependent's adoption or placement for adoption, the date of adoption or placement.

Uniform requirements and participation rules. Requirements used by a small employer carrier in determining whether to provide coverage to a small employer would have to be applied uniformly among all small employers applying for coverage or receiving coverage from the small employer carrier. However, a small employer carrier could deny coverage to a small employer if the small employer failed to enroll enough of its employees (either as a number or percentage) to meet the carrier's minimum participation rules. If a small employer carrier waived a minimum participation rule for a small employer, the carrier could not later enforce that minimum participation rule for that small employer.

Carriers would have to establish minimum participation rules according to sound underwriting requirements, and the rules would be subject to the following limitations:

- for a small employer of 10 or fewer eligible employees, a rule could require enrollment of up to 100 percent of the small employer's employees seeking health care coverage through the small employer;

- for a small employer of 11 to 25 eligible employees, a rule could require enrollment of up to 75 percent of the small employer's employees seeking health care coverage through the small employer;

- for a small employer of 26 to 40 eligible employees, a rule could require enrollment of up to 65 percent of the small employer's employees seeking health care coverage through the small employer; and

- for a small employer of 40 to 50 eligible employees, a rule could require enrollment of up to 50 percent of the small employer's employees seeking health care coverage through the small employer.

Guaranteed renewal. A small employer carrier that offered health coverage in the small employer group market in connection with a health benefit plan would have to renew the plan or continue the plan in force at the option of the small employer or sole proprietor, with certain exceptions. Specifically, guaranteed renewal would not be required in cases of fraud or intentional misrepresentation of the small employer or, for coverage of an insured individual, fraud or misrepresentation by an insured individual or his or her representative; lack of payment; or noncompliance with minimum participation or employer contribution requirements. Also, guaranteed renewal would not be required if the small employer carrier no longer offered that particular type of coverage in the market or if the sole proprietor or small employer moved outside the geographic area.

Discontinuation of plans in geographic area. BCBSM could not cease to renew all health benefit plans in a geographic area, but other carriers could. A small employer carrier that decided to discontinue offering all health benefit plans in a geographic area would have to do all of the following:

- provide notice of the discontinuation to the commissioner and to each small employer that it covered in the discontinued area at least 180 days before the discontinuation of coverage;

- discontinue all plans issued or delivered for issuance in the area and not renew any current health plan in the area;

- refrain from issuing or delivering for issuance any small employer health benefit plans in the area for a five-year period beginning on the date of the discontinuation of the last health coverage not renewed; and

- refrain for five years from issuing any health coverage in any area that was not one of its geographic areas on the date of the notice of the discontinuation of health coverage.

Information from carrier to employer. Each small employer carrier would have to provide all of the following to a small employer upon request and upon entering into a contract with the small employer:

- the extent to which premium rates for a specific small employer were established or adjusted due to

any permitted characteristic and rating factors of the employees of a small employer and dependents;

• the provisions concerning the carrier's right to change premiums, permitted characteristics, and any rating factors that would cause changes in premiums; and

• provisions relating to the renewability of coverage.

Actuarially sound methods and practices. Each small employer carrier would have to maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation demonstrating that its rating methods and practices were based on commonly accepted actuarial assumptions and were in accordance with sound actuarial principles. Small employer carriers would have to make this information and documentation available to the commissioner upon request, but it would not be subject to disclosure under the Freedom of Information Act to persons outside of OFIS, unless agreed to by the small employer carrier or ordered by a court of competent jurisdiction.

Further, on March 1 of each year, each small employer carrier would have to file with the commissioner an actuarial certification that the carrier was in compliance with these requirements and that the rating methods of the carrier were actuarially sound. A copy of this actuarial certification would also have to be retained by the carrier at its principal place of business. These requirements would not replace requirements of the applicable filing provision in the insurance code or in the BCBSM act.

Suspension of requirements by commissioner and attorney general. Upon a filing for suspension by the small employer carrier and a finding by the commissioner, after consulting with the attorney general, that either the suspension was reasonable in light of the financial condition of the carrier or that the suspension would enhance the efficiency of the marketplace for small employer health insurance, the commissioner could suspend the following requirements: all or any part of the provisions governing rates; and the provisions requiring small employer carriers that discontinue all plans in a geographic area to refrain from issuing plans in either that area or any area that were not served by the carrier for a period of five years.

BCBSM. The bill would specify that BCBSM is subject to Section 619 of the Nonprofit Health Care Corporation Act, which deals with civil actions and relief. (While BCBSM is generally subject to all provisions of that act, House Bill 4279 proposes to add a provision stating that Chapter 37 supersedes the provisions of the Nonprofit Health Care Corporation Act in case of a conflict.)

Evaluation of market competitiveness. By March 1, 2006, and by each March 1 thereafter, the commissioner would have to determine whether a reasonable degree of competition in the small employer carrier health market existed on a statewide basis. If the commissioner determined that there was not sufficient competition, he or she would have to hold a public hearing and issue a report delineating specific classifications and kinds of types of insurance, if any, where competition did not exist, as well as any suggested statutory or other changes necessary to increase or encourage competition. The report would have to be based on relevant economic tests and would have to give appropriate weight to all measures of competition rather than focusing exclusively on a single measure.

If the results of the report were disputed or if the commissioner determined that relevant circumstances had changed, the commissioner would have to issue a supplemental report that included a certification of whether or not a reasonable degree of competition existed in the market. The supplemental report certification would have to be supported by substantial evidence and would have to be issued by the December 15 of the year the original report was issued.

These reports and certifications would have to be forwarded to the governor, the clerk of the House, the secretary of the Senate, and all the members of the Senate and House of Representatives' standing committees on insurance and health issues.

In making her or his determinations, the commissioner would have to consider all of the following:

• the extent to which any carrier controlled all or a portion of the small employer carrier health benefit plan market;

• whether there were enough small employer carriers writing small employer health benefit plan coverage in the state to provide multiple options to employers;

• the disparity among small employer health benefit plan rates and classifications to the extent that those classifications resulted in rate differentials;

• the availability of small employer health benefit plan coverage to employers in all geographic areas and all types of business;

• the overall rate level that was not excessive, inadequate, or unfairly discriminatory; and

• any other factors the commissioner considered relevant.

HMO contracts: "off-label" drug coverage. Public Act 538 of 2002 amended the Insurance Code to specify that policies and certificates that provide pharmaceutical coverage must cover "off-label" uses of FDA-approved drugs and the costs of supplies that are medically necessary to administer the drugs. The act imposed a similar requirement on HMO contracts, but did not restrict this requirement to HMO contracts that provide pharmaceutical coverage.

The bill would amend the HMO requirement so that only HMO contracts that provide pharmaceutical coverage would have to cover off-label uses of FDA-approved drugs and the costs of medically necessary supplies.

House Bill 4279

Exemption from utility usage taxes and fees. The act declares that BCBSM is a charitable and benevolent institution and exempts its funds and property from state and local taxes. The bill would exempt BCBSM from utility usage taxes and utility usage fees imposed by the state or by any political subdivision of the state.

Adequate and unimpaired surplus. Section 205 requires BCBSM to maintain a contingency reserve of 65-150 percent of the target contingency reserve level. The target contingency reserve level is established by the commissioner each year according to a methodology set forth in the act. The contingency reserve is funded by subscribers' contributions for risk and contributions for planwide viability. While contributions for risk are determined as part of the normal rate-making process, rates for contributions for planwide viablility depend on the actual level of the contingency reserve and the type of subscriber. (Small group and nongroup subscribers stop making contributions for planwide viability once the actual contingency reserve exceeds 95 percent of the target level, and medium group and large group subscribers make contributions until the reserve exceeds 105 percent of the target level.) If the contingency reserve exceeds 150 percent of the target level, BCBSM must make adjustments to reduce its reserves. If the contingency reserve exceeds the required range at the end of a calendar year, BCBSM must make adjustments to achieve the require range and must file with the commissioner a description of the adjustments.

Also, the commissioner is required to examine BCBSM's annual financial statement to determine whether the contingency reserve is outside the required range, and if it is outside the required range at the end of two successive calendar years, BCBSM must file a plan, with the commissioner, to adjust the contingency reserve to a level within the required range. If the commissioner disapproves the plan, he or she must formulate a plan and forward the plan to BCBSM, which then must implement it.

The bill would replace the act's contingency reserve provisions with a requirement that BCBSM possess and maintain "unimpaired surplus" in an amount determined adequate by the commissioner. Specifically, the commissioner would have to determine that BCBSM's unimpaired surplus was sufficient to put it in compliance with a section of the Insurance Code (Section 403) requiring insurers to be "safe, reliable, and entitled to public confidence". In making this determination, the commissioner would have to follow the risk-based capital requirements as developed by the National Association of Insurance Commissioners (NAIC).

If BCBSM filed a risk-based capital report that indicated that its surplus was less than the amount determined to be adequate, it would have to prepare and submit a plan for remedying the deficiency in accordance with risk-based capital requirements adopted by the commissioner. As part of its plan, BCBSM could propose that subscribers be required to make planwide viability contributions to surplus. The commissioner would have to approve the actual contribution rate for planwide viability contributions, subject to the following limits:

• If BCBSM's surplus was less than 200 percent but more than 150 percent of the "authorized control level" under risk-base capital requirements--i.e., the number determined under the risk-based capital formula in accordance with the instructions developed by the NAIC and adopted by the commissioner--the maximum contribution rate would be one-half of one percent of the rate charged to subscribers for the benefits provided.

• If BCBSM's surplus was 150 percent or less than the authorized control level under risk-based capital requirements, the maximum contribution rate would

be one percent of the rate charged to subscribers for the benefits provided.

In any event, BCBSM could not maintain surplus in an amount that equaled or exceeded 200 percent of the authorized control level under risk-based capital requirements multiplied by five. If BCBSM filed a risk-based capital report indicating that its surplus exceeded this maximum allowable surplus for two successive calendar years, it would have to file a plan for approval by the commissioner to adjust its surplus to a level below the maximum allowable surplus. If the commissioner disapproved BCBSM's plan, the commissioner would be required to formulate an alternate plan and forward that alternate plan to BCBSM. BCBSM would have to begin implementation of the plan immediately upon receipt of approval of its plan by the commissioner or upon receipt of the commissioner's alternate plan.

The bill would replace various references to the act's current contingency reserve requirements with references to the proposed unimpaired surplus requirements.

Lines of business. Section 205 requires BCBSM to define at least five lines of business and to assign a risk factor to each line of business. The bill would eliminate these requirements.

Statutory accounting principles. Section 205 of the act requires BCBSM to record or estimate its liabilities at reasonable values "neither excessive nor inadequate, and in accordance with sound actuarial practices and generally accepted accounting principles to provide for the payment of all debts of the corporation."

The bill would repeal Section 205 and replace the requirement that BCBSM use "generally accepted accounting principles" with a requirement that it report financial information in conformity with sound actuarial practices and "statutory accounting principles" in the same manner designated by the commissioner for other carriers as specified in the Insurance Code. In addition, the bill would permit BCBSM to use approved permitted practices until January 1, 2007 to effectuate the transfer to statutory accounting principles. (For other changes relating to the repeal of Section 205 see "Adequate and unimpaired surplus" and "Lines of business" earlier in the analysis.)

Investment of funds. Under current law, BCBSM may invest and reinvest its funds in, and engage in a variety of other investment-related activities with, entities other than domestic, foreign, or alien insurers. The bill would specify that BCBSM was subject to Chapter 9 (Investments) of the insurance code when investing in such entities.

Also, currently BCBSM may invest in domestic, foreign, and alien insurance companies under certain conditions, but such investments cannot result in BCBSM's owning or controlling ten percent or more of the voting securities of any insurance company. The bill would create an exception allowing BCBSM to own or control part or all of an insurance company authorized only to sell long-term care insurance. In that case, the long-term care insurer could not be exempt from taxation after the acquisition, would need to have a governing board separate from BCBSM's board of directors, and would have to transfer its domicile to Michigan as soon as possible after the acquisition (assuming it was not already domiciled here). The transaction would also have to satisfy the requirements of Chapter 13 of the Insurance Code, which regulates insurance holding companies.

Prohibit conditioning sale of one product on another. The bill would prohibit BCBSM from conditioning the sale or varying the terms or conditions of any product sold by BCBSM or a person controlled by BCBSM, by requiring the purchase of any other product from BCBSM or a person controlled by BCBSM.

Small group market requirements. Under the bill, BCBSM would be subject to Chapter 37 of the insurance code. (House Bill 4553 proposes to add Chapter 37, which would regulate small employer group health care coverage. For more see "House Bill 4553" later in this analysis.) The bill would state that to the extent that a provision of the BCBSM act concerning health coverage, including, but not limited to premiums, rates, filings, and coverages, conflicted with Chapter 37 of the Insurance Code, Chapter 37 would supersede the BCBSM act.

Prescription drug coverage for nongroup and group conversion subscribers. The rates charged to nongroup and group conversion subscribers for a certificate that included prescription drug coverage under House Bill 4281 could include rate differentials based on age, but could have no more than eight separate age bands. BCBSM would have to file its rates for such coverage in accordance with the requirements for other rate filings. (See "Rate filing and approval/disapproval" later in the analysis.)

Conditions for long-term care coverage. The bill would allow BCBSM to condition the granting of

long-term care coverage based on answers given on a required application and according to BCBSM's underwriting standards. (For more on the application and conditions under which BCBSM could charge different rates based on age for the same long-term care coverage, see the summary of House Bill 4280 later in the analysis.)

Contracts for reimbursement. Under current law, BCBSM may enter into participating contracts for reimbursement with professional health care providers practicing legally in Michigan for health care services that the professional health care providers may legally perform. Contracts are subject to Part 5 of the act.

The bill would allow BCBSM to enter into contracts with health practitioners practicing legally in any other jurisdiction as well, as long as it did not do so "for the purpose of disadvantaging a Michigan health care provider or replacing a participating contract with a Michigan health care provider." The bill would specify that contracts with health practitioners practicing legally in Michigan were subject to Part 5.

Rate filing and approval/disapproval. Currently, BCBSM must submit a copy of any new or revised certificate to the commissioner along with applicable proposed rates and a rate rationale. Certificates and applicable proposed rates are considered approved and effective 30 days after filing with the commissioner, unless the commissioner disapproves them or approves them with modifications, according to conditions set forth in the act. The commissioner may subsequently disapprove any certificate that previously had been deemed approved. Finally, upon request, the commissioner may allow certificates and rates to be implemented prior to filing to allow implementation of a new certificate on the date requested.

The bill would specify instead that if BCBSM wanted to offer a new certificate, change an existing certificate, or change a rate charge, a copy of the proposed certificate, proposed revised certificate, or proposed rate would have to be filed with the commissioner and could not take effect until 60 days after the filing unless the commissioner approved the change in writing before the expiration of the 60-day period. (These requirements would not apply to rates and certificates for nongroup Medicare supplemental subscribers; see "Nongroup Medicare supplemental rates and timelines" later.) The commissioner could still disapprove the certificates or rates or approve them with modifications, according to the conditions currently set forth in the act, but the bill would specify that notices of approval, approval with modifications, or disapproval must be written notices. Also, the bill would specify that the commissioner could subsequently disapprove any certificate or rate charge. The commissioner could still allow certificates and rates to be implemented prior to filing to allow timely implementation of a new certificate.

Commissioner - hearing. The bill would require the commissioner to schedule a hearing not more than 30 days after receipt of a written request from BCBSM. A revised certificate, revised proposed certificate, or proposed rate could not take effect until approved by the commissioner after the hearing. Within 30 days after the hearing, the commissioner would have to notify BCBSM in writing of the disposition of the revised certificate, revised proposed certificate, or proposed rate, together with the commissioner's findings of fact and conclusions.

Attorney general - hearing. The bill would add a requirement that, upon receipt of a rate filing, the commissioner notify the attorney general and provide to the attorney general a copy of the proposed rate revision. Upon making a written request for a hearing within 30 days after receiving notice of the rate filing, the attorney general would have an opportunity for an evidentiary hearing to determine whether the proposed rates met the requirements of the act. The request would have to identify the issues that he or she asserted were involved and what portion of the rate filing was to be heard. If the attorney general requested an evidentiary hearing, the commissioner could not approve, approve with modifications, or disapprove a filing until the hearing had been completed and an order had been issued.

Prior approval and review of rating methodologies and definitions. Currently, the methodology and definitions of each rating system, formula, component, and factor used to calculate rates for BCBSM's group subscribers for each certificate must be filed with the commissioner and are subject to the commissioner's prior approval. The commissioner must approve, disapprove, or modify and approve the methodologies and definitions of each rating system, formula, component, and factor for each certificate, subject to the standard that the resulting rates for group subscribers must be equitable, adequate, and not excessive. Also, the commissioner may from time to time review BCBSM's records to determine proper application of a rating system, formula, component, or factor with respect to any group. BCBSM must refile for approval every three years. The bill would eliminate these provisions.

Section 619 - civil actions and relief. Currently, Section 619 of the act allows the attorney general to bring an action, or apply to the circuit court for a court order, to enjoin BCBSM from transacting business, receiving, collecting, or disbursing money, or acquiring, holding, protecting, or conveying property if that corporate activity was not authorized under the act. In addition, Section 619 allows the attorney general to apply to the circuit court for a court order enjoining an alleged violation of the act or other equitable or extraordinary relief to enforce the act. The bill would specify instead that the attorney general could bring an action, or apply to the circuit court for a court order to enjoin BCBSM from engaging in a corporate activity not authorized under the act *or under Chapter 37 of the Insurance Code*. Likewise, the attorney general could apply to the circuit court for a court order enjoining an alleged violation of the act *or Chapter 37 of the Insurance Code* or other equitable or extraordinary relief to enforce the act *or Chapter 37*.

Finally, Section 619 currently authorizes a political subdivision of the state, an agency of the state, or any person to bring an action in the Ingham County Circuit Court for declaratory and equitable relief against the commissioner or to compel the commissioner to enforce the act. Under the bill, such parties could also bring an action in the Ingham County Circuit Court to compel the commissioner to enforce Chapter 37 of the Insurance Code.

Nongroup medicare supplemental rates and timeline. The act prescribes a timeline for BCBSM to file all rate information and materials and for the commissioner to approve or disapprove the rates. Under the bill, the timeline would apply only to nongroup Medicare supplemental rates. Thus, rates charged to nongroup Medicare supplemental subscribers would have to be filed with the commissioner and would be subject to the commissioner's prior approval. However, the bill would eliminate a provision that would otherwise allow BCBSM to implement rates prior to approval in the event that BCBSM was participating with one or more "health care corporations"—that is, one or more other health care corporations incorporated under the act, of which there are currently none--to underwrite a group whose employees are located in several states.

Other provisions. In addition to the above changes, House Bill 4279 would:

- add limited liability companies to the act's definition of "person";
- update references to the Insurance Code, the Public Health Code, and the Business Corporation Act;
- update references to the (federal) Social Security Act; and
- delete references to the defunct Michigan Caring Program.

House Bill 4280 would amend the Nonprofit Health Care Corporation Act (MCL 550.1420a et al.) to allow Blue Cross Blue Shield of Michigan to use an application form for long-term care coverage that was designed to elicit the applicant's complete health history. As discussed earlier, House Bill 4279 would expressly permit BCBSM to condition the granting of long-term care coverage based on answers given on such an application. House Bill 4280 is tie-barred to House Bill 4279, meaning it could not take effect unless House Bill 4279 was also enacted.

BCBSM could charge a different rate based on age for the same long-term coverage if the rate differential was based on sound actuarial principles and a reasonable classification system, and was related to actual and credible loss statistics or, for new coverage, was related to reasonably anticipated experience.

If BCBSM offered long-term coverage in Michigan, the sale of that coverage would not be exempt from taxation by the state or any political subdivision of the state.

House Bill 4281 would amend the Nonprofit Health Care Reform Act (MCL 550.1401i) to add a requirement that, beginning January 1, 2004, BCBSM establish and offer to provide or include prescription drug coverage in at least one nongroup and group conversion certificate, as a pilot project. A certificate that included prescription drug coverage under the pilot project would have to include all of the following:

- at a minimum, a prescription drug benefit that included a co-pay of not more than 50 percent of BCBSM's approved amount for the payment of prescription drugs, with a minimum co-pay of $10 and a maximum co-pay of $100;
- an annual per person benefit maximum of no less than $2,500; and
- a provision that members were entitled to purchase prescription drugs at a discount under the Affinity program offered by BCBSM once their annual per

person prescription drug benefit maximum had been reached. (As described by the Office of Financial and Insurance Services, the Affinity program allows eligible members to present their BCBSM identification card to participating pharmacies and purchase prescription drugs a discounted rate negotiated with pharmacies by BCBSM.)

The pilot project would have to continue through July 1, 2006 and would not be subject to the act's guaranteed renewability provisions.

Not later than July 1, 2005, BCBSM would have to issue an interim report to the Commissioner of the Office of Financial and Insurance Services regarding the claims experience of the nongroup and group conversion market and the ongoing viability of the pilot project. Not later than July 1, 2006, BCBSM would have to issue a final report with the same content. By September 30, 2006, the commissioner would have to determine if the nongroup and group conversion certificate providing the prescription drug benefit under the pilot project provided a useful benefit to its subscribers. If the commissioner determined that the benefit was not useful, he or she could order that the program be terminated and could terminate the offering of prescription drug coverage in the nongroup and group conversion certificates. If the commissioner determined that the benefit was useful, he or she could order that the program be continued indefinitely, though the certificates would then be subject to the act's guaranteed renewability provisions.

House Bill 4282 would amend the Nonprofit Health Care Reform Act (MCL 550.1501) to allow BCBSM to enter into contracts with health care facilities in Michigan or health facilities in any other jurisdiction. However, BCBSM could not enter into contracts with health facilities out of state "for the purpose of disadvantaging a Michigan licensed health care facility or replacing a contract with a Michigan licensed health care facility."

Currently, the act states only that BCBSM may enter into contracts with health care facilities and that those contracts are subject to requirements set forth in Part 5 of the act. The bill would specify that contracts with health care facilities in Michigan are subject to Part 5.

FISCAL IMPLICATIONS:

There is no fiscal information at present.

ARGUMENTS:

For:

The bills would go a long way toward achieving what many people believed was simply not possible: to help Blue Cross Blue Shield of Michigan and encourage competition in the small employer group health insurance market. As the state's largest insurer, and historic insurer of last resort, the state needs to support BCBSM. BCBSM insures far too many Michigan residents—and notably, far too many of Michigan's older, sicker, and higher-risk residents--to allow the company to suffer the kinds of losses that it has endured in the small group market in recent years. Neither can the state afford to ignore the realities of the health insurance market. To the extent that it does, commercial carriers and HMOs will flee from the state, seeking markets under the jurisdiction of regulators and legislators who better understand the relationship between premiums, actuarially sound rating characteristics and practices, and the need to pay (ever increasing) health care costs. Customers, including small businesses, will lose currently available options, and the state will become increasingly dependent on, and beholden to, the fate of BCBSM.

Small group market reform is not a new concept. Many states began their reforms in the early 1990s, and federal legislation enacted in 1996—HIPAA—required all carriers who insure small employer groups to guarantee "issue" and "renewability" of coverage to businesses and other employers of 2-50 employees. However tempting it may be to forge a new path, Michigan's relatively late foray into small group market reform has allowed the many groups and individuals who have developed the current package time to reflect on, discuss, and debate the experiences of other states as well as characteristics unique to Michigan's market. Besides, while federal regulators have overlooked Michigan's failure to enact HIPAA requirements, sooner or later the state will have to comply.

One tool that has been endorsed by the National Association of Insurance Commissioners (NAIC) and has been employed throughout the country with varying degrees of success is the concept of a rate band. Rate bands limit the amount of difference between an insurer's highest and lowest premium for a given health benefit plan. Where all carriers play by the same rules, it makes sense to make the rate bands identical for each carrier. In Michigan, however, commercial insurers are regulated under certain provisions of the Insurance Code, HMOs are

regulated under separate provisions of the Insurance Code, and BCBSM is regulated under the Nonprofit Health Care Corporation Act. Among the many distinctions between these different types of carriers is the different type of characteristics that they have been allowed to use in setting premiums. Most notably, BCBSM has not been allowed to use age or health status, while commercial carriers have been allowed to use such characteristics.

By allowing BCBSM to use age and other characteristics to set premiums but constricting the variance due to these characteristics, and by confining commercial carriers' use of health status within a specific range (while still allowing them to employ other more objective characteristics), House Bill 4553 would narrow the gap between BCBSM's rates and commercial carriers' rates in the small group market. The secondary limitation on commercial carriers' use of age is a compromise intended to give commercial carriers some flexibility to rate by age but not so much that their rate band would be so broad that they could still consistently outbid BCBSM on younger groups. Permitting different rules for different types of carriers may seem unfair, but each type of carriers has different advantages and disadvantages. While commercial carriers have a distinct advantage in the types of characteristics they may use, BCBSM has distinct advantages due to its market share, which allows it to negotiate better payment rates with health care providers and facilities, and due to its tax exemptions. As long as BCBSM enjoys these advantages, some "texture" is needed in any proposal to introduce more parity into the health insurance market.

By compressing commercial carriers' rates and decompressing BCBSM's rates, the bills would narrow the gap between premiums offered by the different types of carriers and would thereby make it easier for BCBSM to compete with commercial carriers for younger (if not necessarily healthier) groups. This would help reduce the amount of adverse selection and help eliminate the death spiral. By phasing in the rate bands, the bills would allow the different carriers time to adjust to the new rules. The other feature of House Bill 4553 that would help reduce adverse selection is the provision allowing small employer carriers to employ participation rules. This would give BCBSM some means of assuring that commercial carriers, and their agents, did not split small groups in two and leave the sickest employees for BCBSM. Wisely, the bill would limit participation rules to those employees who were actually seeking coverage through their employer: an insurer could not require participation by employees who have coverage through a spouse or those who chose to "go bare" by not having health insurance at all.

House Bill 4553 would also go beyond HIPAA in requiring carriers that offered coverage to any sole proprietor to make that coverage available to other sole proprietors as well. Sole proprietors could be charged an additional premium, and sole proprietors who tried to get by without insurance would face additional premiums when first purchasing insurance. This would allow those sole proprietors who really did not want coverage to opt out, while penalizing sole proprietors who shifted in and out of the market based on fluctuations in their need for health coverage.

The bills do have their limitations. No one has ever claimed that the bills would lower health care costs. Also, no one claims that the bills would lower health insurance costs overall. While some people would experience lower premiums, others, including commercial carriers' younger and healthier groups and BCBSM's older groups, would see their premiums rise. Despite these limitations, the bills will likely flatten out some of the spikes in health insurance premiums for small groups and bring more stability to the small group health insurance market.

Response:

House Bill 4553 would treat individuals differently depending on whether their policy is a renewal or a new policy issued on or after the bill's effective date. Some people question whether this would satisfy HIPAA's requirement that small employer carriers treat similarly situated individuals similarly.

For:

House Bill 4553 also helps protect employees from paying premiums based on their age, health status, and other factors. Under the proposal, carriers would have to bill small employer groups with a composite rate, so that employers would not be able to charge employees different amounts for their insurance. While employers are increasingly passing along a portion of the health insurance premium to their employees and routinely require an employee with covered dependents to pay more than those without covered dependents, one employee should not have to pay more than another based on age or health status, and it is better that employers not have this information.

Response:

If the intent of the composite billing requirement is that insurers bill with an aggregate rate while still

allowed to use case characteristics to determine what an individual employee will cost to insure, this should be clarified. As it stands, requiring small employer carriers to bill small employer groups "only with a composite rate" might be interpreted to mean that carriers could not use case characteristics in establishing premiums.

Against:

Employers are increasingly passing along a portion of the health insurance premium to their employees. If insurers are allowed to use age as a rating factor, then employers should be allowed to transmit this information to their employees and, ultimately, to charge individual employees different amounts for their coverage. A younger employee should not have to subsidize an older employee's health care coverage.

Response:

Group health insurance coverage is based on the notion that individual members of the group subsidize the coverage for other members of the group.

For:

House Bill 4281 would require BCBSM to establish a pilot project to offer a prescription drug benefit in at least one nongroup and group conversion certificate. Many sole proprietors apply for group coverage rather than nongroup coverage because nongroup coverage does not contain a prescription drug benefit. House Bill 4281 would make nongroup coverage more attractive for sole proprietors. Since older people tend to use more prescription drugs than younger people, and BCBSM wants to make nongroup coverage attractive to sole proprietors and other individuals of all age, House Bill 4279 wisely allows BCBSM to use an age differential for certificates that include the drug benefit.

For:

House Bills 4279 and 4282 would allow BCBSM to contract with health care providers and facilities outside of Michigan, in an effort to provide equal levels of service and access to members whether or not they were in Michigan when they needed medical attention. This would help BCBSM control costs for members who want to use the world-class facilities of the Mayo Clinic or the Cleveland Clinic or members who get sick when traveling out of state. The bills would also protect in-state providers and facilities by prohibiting BCBSM from entering into such contracts "for the purpose of disadvantaging" or "replacing" contracts with providers and facilities in Michigan.

Response:

The language restricting BCBSM's ability to contract with out-of-state providers and facilities is by some accounts too broad and by other accounts too weak. Some people believe that it would be virtually impossible to show that BCBSM was entering such contracts "for the purpose of" getting rid of contracts with providers and facilities in Michigan, while others believe that the word "disadvantaging" such providers and facilities is open to too much interpretation.

For:

House Bill 4280, in conjunction with House Bill 4279, would allow BCBSM to obtain a long-term care insurance applicant's health history and would allow BCBSM to use age as a factor in determining rates. The act already allows BCBSM to sell a long-term care product, but does not specifically permit rating by age. While typically an individual's long-term care premium does not increase with age, the price does vary depending upon when someone first purchases coverage. Like life insurance, long-term care insurance gives a benefit that people receive towards the end of their lives. With carriers and agents already struggling to generate interest in long-term care coverage, few would try to convince a 30-year old that she should pay the same premium for a 60-year old for the same end of life benefit. Likewise, BCBSM cannot sell such a product without considering the health-status of applicants to determine which product is best suited to them.

Against:

Blue Cross Blue Shield of Michigan is Michigan's insurer. It has historically operated as the state's insurer of last resort, guaranteeing health insurance to anyone who wants it. While the declared intent of the legislation has been to help BCBSM, in their present form the bills cater too much to the wishes of commercial insurers who compose a tiny fraction of Michigan's insurance market.

In particular, some people believe that House Bill 4553's secondary rate limitation for commercial carriers, the maximum premium differential for age of 5 to 1, is too wide. This differential would allow commercial carriers to continue adversely selecting against older groups and would permit the death spiral to continue. Some argue that a maximum premium differential of 3 to 1 for age is more sound from an actuarial perspective and would adequately offset the advantages that BCBSM's market share and tax exemptions give it. Others argue that the differential for age should be less than 3 to 1 initially

and should be reduced over time. Putting a limit of 3 to 1 in statute would effectively establish 3 to 1 as the standard premium differential for age. Still others believe that age should simply be put within the rate band for all carriers.

Response:

One declared intent of the legislation is to help BCBSM transition to the contemporary health insurance market. Another is to increase competition in the small group health insurance market, with the hope that small employers will start to see more attractive options. It is disingenuous to refer to BCBSM's tremendous market advantage as a "given", let alone a reason to continue old policies or develop new policies that will allow BCBSM to keep or enlarge that advantage. In essence, BCBSM is a behemoth of the state's own creation, and retaining the few advantages that commercial carriers and HMOs currently have is necessary if small employers are ever to see the benefits of a truly competitive marketplace.

Against:

Blue Cross Blue Shield of Michigan is Michigan's largest insurer. Between its state and local tax exemptions and the tremendous leverage that its market dominance entails, BCBSM should not need any (additional) help whatsoever. BCBSM describes itself as a benevolent and charitable institution yet in this proposed legislation it seeks to acquire a long-term care insurance company, the ability to contract with health care providers and facilities out of state, new tax and fee exemptions, and other advantageous benefits. By expanding BCBSM's powers and easing current restrictions on BCBSM while retaining its tax exemptions and imposing constraints on commercial insurers, the bills go a long way toward ensuring that BCBSM will retain (and even enlarge) its market share for years to come. If the state wants BCBSM to have a monopoly on insurance in Michigan, then BCBSM should be regulated like a monopoly. Otherwise, the state should allow the free market to determine insurance rates.

Critics say that the proposed rate bands are by far the most dangerous aspect of the bills. The concept of rate bands is part of the National Association of Insurance Commissioner's model act. Critics say that each state that has adopted the NAIC model has basically seen three effects: prices go up, the number of uninsured people increases, and employees see higher costs of insurance. If mild, these effects are not necessarily bad. Legislators need to decide whether they are willing to accept such effects in return for the benefit of flattening out the spikes in health insurance costs for small employers and their employees. If they are willing to accept this cost, then they need to understand that imposing rate bands on commercial carriers and HMOs is essentially a means of controlling their prices. House Bill 4553 will result in premium increases for some groups (notably the premiums of younger groups insured by commercial carriers and older groups insured by BCBSM) and premium decreases for other groups (notably the premiums of younger groups insured by BCBSM and older groups insured by commercial carriers). How significant will these increases and decreases be? No one really knows. If the bills pass, all other carriers will essentially be waiting to see what BCBSM does with its rates and will have to respond. To the extent that commercial carriers find themselves forced to make plans available to older, sicker groups at rates that do not cover the risk they represent, they will simply leave the state and focus on doing business in friendlier climates. While commercial carriers and agents often balk at accusations of cherry picking, many concede that it happens. Still, the bill favors BCBSM so much that it could start cherry picking against the commercial carriers and HMOs. At the very least, the legislature should perform an in-depth analysis of the possible effects of the legislation on rates and the level of uninsured.

Given the current structure of the (primary) rate bands, either the use of age should be limited only by actuarially sound rating methodologies, or it should be limited to a maximum premium differential closer to 10 to 1 rather than the bill's current 5 to 1 ratio. Certainly anything less than 5 to 1 would be too restrictive. Yet the current structure of the rate bands leaves much to be desired. Some commercial carriers argue that applying the current definition of "index rate" to commercial carriers essentially forces all characteristics within the rate bands. They also argue that limiting commercial carriers' annual adjustments for changes in a group's characteristics to 15 percent, when BCBSM and HMOs would be permitted a 35 percent annual change, is unfair.

While supporters of the rate bands cite the NAIC model act as their model, the states where this model has been implemented successfully have not made the distinction between the different types of carriers that House Bill 4553 proposes. Proponents call the distinctions between the proposed legislation and the NAIC model act "texture," but only when those distinctions work significantly to the advantage of BCBSM.

In general, it would be better to take a more incremental approach to reform. One possibility might be simply to allow BCBSM to use participation rules as a means of securing against cherry picking. The latest financial reports indicate that BCBSM is making money in the small group market again, and drastic changes such as those proposed by the bills may not be necessary. If these changes are to be made, then at the very least the legislature should perform an analysis of the bills' effects on rates and should put a sunset date on House Bill 4553, so it is forced to revisit the issue. The legislature has not seriously looked at the Nonprofit Health Care Corporation Act since 1980, and while some people joke that they hope they are not around when the next revision is necessary, others suggest that the citizens would be well served by having legislators who have developed some expertise and historical background on the issues examine the bills' effects in the next few years.

Again, one of the potential dangers of enacting legislation that swings too far in BCBSM's favor is that commercial carriers will leave the state. If this happens, competition will suffer and small employers will lack any real choices in the health care insurance market. All small employers agree that health care costs are a problem. While the bills will not control these costs, they should not drive insurers currently operating in the state away, and they should attract insurers not operating in the state to Michigan. Some commercial carriers and representatives of small businesses who do not support the legislation believe that certain trade associations have lost sight of the importance of competition because they receive commissions from BCBSM that supplement, and in some cases effectively replace, membership dues. Such conflicts of interest obstruct these organizations' view of what small employer really want. While BCBSM is the dominant player in the small group health insurance market today, this should not be used as a reason to maintain or increase its market share now or in the future.

Response:

While commercial carriers paint a David and Goliath picture in which they struggle heroically against the BCBSM giant, they neglect to acknowledge BCBSM's historic mission to insure all state residents affordably—a much more formidable struggle, which commercial carriers flee instinctively. BCBSM and the small businesses and associations supporting the concepts proposed by the legislation do not suggest that BCBSM has a right to market dominance. Rather, they believe that BCBSM should have the tools necessary to make sure that its market share—whatever that may be—is a more or less representative sample of the state's population.

Against:

Despite BCBSM's attempts to connect them, the nature of the relationship between House Bills 4279-4282 and House Bill 4553 is unclear. The amendments to the governing statute are designed to help BCBSM but appear to have no fundamental connection to the issue of small group market reform or BCBSM's mission. In particular, House Bill 4279 would allow BCBSM to acquire a long-term care insurance company. While the company would not be exempt from taxation, BCBSM would still be purchasing the company with tax-exempt funds. Such extensions of BCBSM's scope suggest an interest in broadening its monopoly.

Response:

Last session, the state's insurance commissioner advocated a plan consisting of three components: BCBSM regulatory reform, BCBSM board reform, and small group market reform. The BCBSM act was enacted in 1980 and has not been fundamentally changed since then, despite drastic changes in health care and the health care insurance market. In essence, the BCBSM is "a relic of another age," and the commissioner's plan was designed, in part, to help BCBSM make the transition to modern times, by allowing it to act more like commercial insurers and HMOs in certain ways. House Bill 4553 is also designed to bridge the gap between BCBSM and commercial insurers and HMOs, though only with respect to the small group market where there are specific issues that need to be addressed.

Reply:

BCBSM will remain a "relic of another age", say critics, until it loses its tax exemptions and is forced to compete in the free market. Insofar as supporters appeal to the connection between the current package of bills and the former insurance commissioner's plan, it is noteworthy that they are not advocating board reform this time.

Against:

Advocates for senior citizens are concerned about allowing BCBSM to use age as a factor in setting health insurance premiums and about leaving age outside of commercial carriers' rate band. Some question why legislators would want to take steps that would effectively raise the premiums for employers with older employees at a time when they are encouraging employers to hire older individuals.

At the very least, House Bill 4553 should be phased in over a longer period of time, and the bill's reporting provisions should require reporting on the

issue of adverse selection and the effects of legislation on rates and coverage for specific segments of the population, including the 50 and over segment. During the phase-in period, the commissioner should have the authority to make minor adjustments to the rate bands if he or she found that the bill had resulted in significant rate increases for certain classes of customers or in a significant increase in the number of uninsured. The legislature should have the power to approve or disapprove such an adjustment, but new legislation should not be required to adjust the rate bands.

Against:

HMOs have repeatedly expressed concern that they have found themselves in the middle of what is largely a dispute between commercial carriers and BCBSM. Like commercial carriers, HMOs would see their rates compressed by the rate bands, and some HMOs fear that the inclusion of case characteristics within the rate bands would make it difficult if not impossible to set rates that are actuarially sound. Any legislation should require that carriers' rates reflect their cost of providing services. Also, since so much of the discussion of the bills has focused on the advantages and disadvantages of BCBSM and commercial carriers in the health insurance market, HMOs believe it would be appropriate to consider some of the disadvantages that they face. Of all types of carriers, HMOs have the least flexibility in determining what sorts of benefit plans they can offer. They must offer a broad and comprehensive benefit package to all enrollees, while BCBSM and commercial carriers can offer less comprehensive, and therefore, less expensive packages that may be better suited to the needs of small employers or other segments of the health insurance market. HMOs would like to be able to offer a broader range of products and believe that allowing them to do so would enhance competition and provide employers with the wide range of choices they seek.

POSITIONS:

The Office of Financial and Insurance Services does not have an official position on the bills. (5-28-03)

The Life Insurance Association of Michigan supports House Bill 4553. (5-23-03)

Humana Insurance Company supports House Bill 4553 but is concerned that the bill's phase-in period may not be HIPAA-compliant and that the composite billing language does not reflect the intent of the provision. (5-27-03)

The Detroit Regional Chamber of Commerce supports House Bill 4279-4282. The DRCC does not support House Bill 4553 in its current form, but would support the bill if age was placed inside the rate band for commercial carriers. (5-27-03)

Blue Cross Blue Shield of Michigan supports the bills in concept but has concerns that House Bill 4553 will not stop the problem of adverse risk selection because it leaves some case characteristics, including age, outside of the rate band. (5-23-03)

The Michigan Association of Health Plans supports House Bill 4553 in concept but still has some concerns. (5-23-03)

The Small Business Association of Michigan does not support House Bill 4553 in its current form, but would support the bill with a 3 to 1 maximum premium differential for age for commercial carriers. (5-23-03)

The National Federation of Independent Businesses – Michigan has no official position on the bills. (5-24-03)

Golden Rule of Michigan has no official position on the bills. (5-27-03)

The Health Insurance Association of America opposes House Bills 4279-4282 and does not have an official position on House Bill 4553. (5-22-03)

The AARP of Michigan does not support House Bill 4553 in its current form. (5-23-03)

The Michigan Association of Health Underwriters opposes the bills. (5-29-03)

Fortis Health opposes House Bill 4553. (5-23-03)

Analyst: J. Caver

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.